PATIENT CENTERED MEDICAL HOME

MARYLAND

PCMH

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Improving Chronic Illness Care(ICIC)

Maryland's Patient Centered Medical Home pilot

Beginning in January 2011, Maryland is planning to launch a 50 practice Patient Centered Medical Home (PCMH) pilot.

The PCMH is a model of practice in which a team of health professionals, guided by a personal physician, provides continuous, comprehensive, and coordinated care in a culturally and linguistically sensitive manner to patients throughout their lives.

The PCMH provides for all of a patient's health care needs, or collaborates with other qualified professionals to meet those needs. Participating practices will provide patient centered care through:

- evidence-based medicine;
- expanded access and communication;
- care coordination and integration; and,
- care quality and safety.

News Updates

Regional Provider Symposia- June 22nd, 2010 to July 14th, 2010

Provider Expressions of Interest Due September 2010

Provider Applications Due October 2010

PCMH pilot begins January 2011

More News >

Lt. Governor's Message

As Chair of the Maryland Health Quality and Cost Council and the Co-Chair of the Governor's Health Reform Coordinating Council, I am working with our State government, local government, academic, non-profit, and private partners to implement state-level health care reforms such as the Patient Centered Medical Home Program, an innovative initiative aimed at improving health care quality and reducing health care costs for all Marylanders.

Reaching sustainable numbers of patients

Assumptions:

- A PCMH practice must have > 50% of the practice's patient panel insured by carriers participating in the program.
- Maryland will compete for CMS multi-payer grant – but … Maryland's CMS "EHR Demo" practices may participate in PCMH pilot, but probably will not be eligible for Medicare elevated payments.
- Medicaid participation will be concentrated in pediatric practices and FQHCs.
- Participation of patients covered by self-insured employers will be essential to achieving 50% patient share in most family medicine and internal medicine practices.
- Use an opt-out provision to encourage patient participation.

Attribution of patients

- Start with listing from practice – patients and source of insurance
- Payers determine enrollment:
  - Look for E&M codes 99201-99205, 99211-99215, 99381-99387, 99391-99397, 99432 over the last 24 months
  - If only one provider is the only primary care practice seen, attribute the patient to that practice.
  - If more than one provider ID is present in the 2 year period, look at the providers in the most recent year (year 2).
  - If only one provider is present in the most recent year, attribute the patient to that practice.
  - If more than one provider is present in most recent year, assign to the provider with the plurality of E&M claims in the last 2 years.
  - If no medical claims are present, then link enrollee to pharmacy eligibility.
- Annual update occurs in subsequent years.

Recognizing Medical Homes

- Focus has been on NCQA – PPC-PCMH recognition since initial planning.
  - NCQA recognition has limitations – not sufficiently patient-centered. “Must pass elements” only require a passing grade of 50%, no designation of specific factors is required.
  - Some of the factors required in the NCQA elements are more strongly linked to potential reductions in costs to the purchasers and the patients – these are a priority for Maryland.
  - Pennsylvania has specifically designated some factors in the elements that are required.

- MHCC is considering an NCQA level + method for recognition.
  - To achieve NCQA Level 1, Level 2, Level 3. MHCC will designate “must pass” elements in each of the nine domains. Practices must pass these elements.
  - We will look at draft 2011 standards to determine if proposed changes will affect recommendations. Some of the draft standards move recognition in the direction we would prefer.

NCQA is the most recognized PCMH recognition tool

- Three Levels of Certification based on increasing points earned by meeting standards.
- Ten "must pass" elements for Levels II and III; five of ten necessary for Level I.*
- For Level 1, no priority for which 5 elements are met.

* *There are 30 NCQA elements in total across the nine standards.*
11 Maryland practices have achieved NCQA recognition.

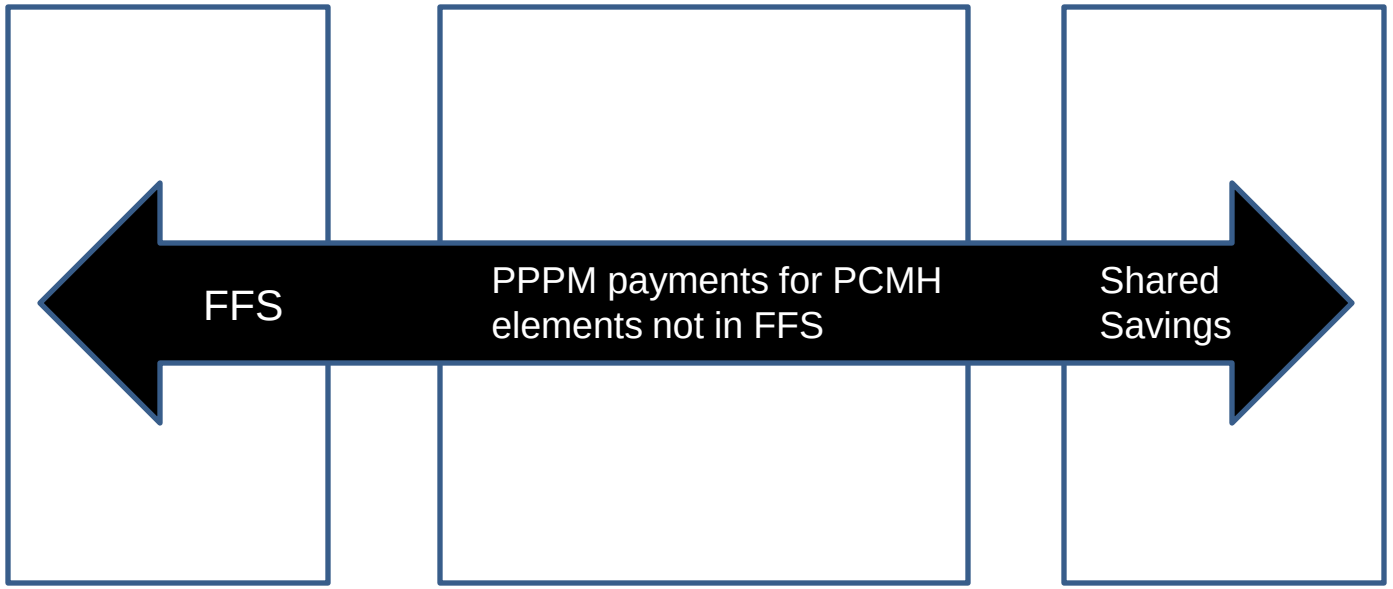
Standards (number of must pass elements)

1. Access and Communication (2)
2. Patient Tracking and Registry (2)
3. Care Management (1)
4. Patient Self-Management Support
5. Electronic Prescribing (0)
6. Test Tracking (1)
7. Referral Tracking (1)
8. Performance Reporting and Improvement (2)
9. Advanced Electronic Communication (0)

NCQA PPC-PCMH "must pass" factors that practices must meet to participate in the Maryland

Maryland PCMH Recognition Criteria			
Requirements (all included in NCQA PCMH Review)	Maryland Recognition Level		
	Level 1 + NCQA Level 1, including Factors	Level 2+ NCQA Level 2, including Factors	Level 3+ NCQA Level 3, including Factors
24-7 phone response with clinician for urgent needs	✓	✓	✓
Registry as part of EHR or as stand-alone	✓	✓	✓
Summary of care record for transitions	✓	✓	✓
Advanced access for appointments	✓	✓	✓
Care management & coordination by specially trained team members	✓	✓	✓
Problem list for all patients	✓	✓	✓
Medication reconciliation every visit	✓	✓	✓
Pre-visit planning and after-visit follow-up for care management	✓	✓	✓
EHR with decision support		✓	✓
Physician-led team with regular communication.		✓	✓
CPOE for all orders; test tracking and follow-up		✓	✓
E-prescribing		✓	✓
Self-management support		✓	✓
Decision support: drug-drug, drug-allergy and drug-formulary			✓
Summary of visit to patient every visit			✓
Reporting of relevant clinical measures			✓

Payment Reform for Primary Care
A Three-Tiered Approach



No change, each carrier uses its own system, as is done today.

PPPM set by NCQA recognition level, payer category, and practice size. Payments are made in lump sum.

Average savings per patient calculated relative to the practice's historical performance.

Payment Methodology

Design Goals: Reward medical homes for the additional services while creating a viable economic model for health care purchasers. For the pilot program, maintain administrative simplicity given the multitude of payers, inclusion of diverse physician practices, and avoiding risk selection against sicker patients.

Underlying Assumptions:

1. Medical homes must generate savings (which are validated through the performance measures) to be self-sustaining.
2. Medical home payment model must support the investments that practices must make in transformation and operation as a medical home.
3. Practices must share (significantly) in savings that result.
4. Practices are "at risk" for performance (as measured through specified measures and/or financial claims analysis) for incentive payments.

Payment Methodology (continued)

MHCC assumes fixed payments awarded prior to achievement of savings and non-refundable.

- Options for delivery of payments by carriers:
  - Initial fixed payment in a lump sum triggered by submission of NCQA application/ recognition. Subsequent payments made on a semi-annual basis.
  - Fixed payments PPPM –
- MHCC prefers initial lump sum payment to enable practices to have a reserve of capital for meeting new PCMH functions.

Approach to incentive payments:

- Incentive payment = (Savings – fixed payment)* practice share where practice's share is not unknown and where practice's share based on average total costs of treatment for the patient.
- MHCC will calculate payment using claim histories from carriers.

Payment Methodology – Fixed Payments for the Commercial and Medicare Populations

Fixed payments cover the costs to the practice of providing additional services that a PCMH practice is required to provide, including after hours care and care coordination. Assume fixed payment would differ by payer type/age, no patient specific case mix adjustment.

Commercial Population Per Member per Month (PMPM) Payments				
Physician Practice Size (# of patients)	Level of PCMH Recognition			
	Level 1+	Level 2+	Level 3+	100% Compliance
< 6,000	$4.68	$5.34	$6.01	$6.68
6,000 - 14,000	$4.29	$4.90	$5.51	$6.12
14,001 - 22,000	$3.90	$4.45	$5.01	$5.57
> 22,000	$3.51	$4.01	$4.51	$5.01
Medicare/Over 65 Population - Recommended Per Member per Month (PMPM) Payments				
< 6,000	$17.50	$20.00	$22.50	$25.00
6,000 - 14,000	$16.04	$18.33	$20.63	$22.92
14,001 - 22,000	$14.58	$16.67	$18.75	$20.83
> 22,000	$13.13	$15.00	$16.88	$18.75

Fixed Payments -- Rationale and Levels

- Fixed payments (FP) are a function of NCQA recognition level, carrier type, and practice size.
- NCQA recognition level – generally accepted in pilots using PPC-PCMH.
- Variations in FP by carrier class reflect empirical work by Discern, LLC and others using known variations in prevalence of chronic and acute conditions.
- Differences in FP by practice size is assumed because:
  - Higher fixed costs of transforming a small practice to a PCMH;
  - Likelihood of greater fluctuations in shared savings for small practices;
  - Proportion of hypothesized savings going to fixed payments are designed to provide incentives for smaller practices to participate, but not a complete offset;
- Attribution approach has a significant impact on per physician payment .

Adjustments to Fixed PMPM Payment Based on Practice Size				
Medical Home Size (# of Patients in the Practice Panel)	Approx. # of FTE Physicians	Fixed Payment Adjustment Factor	% of PCMH Payment Assigned to Fixed Payment	% of PCMH Payment Assigned to Incentive Payment
< 6,000	< 4	1.2	60%	40%
6,000 - 14,000	4 to 8	1.1	55%	45%
14,001 - 22,000	8 to 12	1 (no adjustment)	50%	50%
> 22,000	➢12	.9	45%	55%

Illustration of fixed payments for a "typical practice" in the Maryland PCMH Pilot

		Commercial Patients under 65			
Physician Practice Size (# of eligible patients)	# of Physicians in Practice	Level of PCMH Recognition			
		NCQA Level 1+	NCQA Level 2+	NCQA Level 3+	100% Compliance
3,500	2	$58,968	$67,284	$75,726	$84,168
8,000	5	$45,302	$51,744	$58,186	$64,627
15,000	9	$39,000	$44,500	$50,100	$55,700
25,000	14	$33,846	$38,668	$43,489	$48,311
Assumptions: 50% of eligible patients enroll in PCMH					

		Mixed practice of Commercial Patients under 65, Medicare, Medicaid Patients			
	# of Physicians in Practice	Level of PCMH Recognition			
3,500	2	$74,298	$84,912	$95,526	$106,140
8,000	5	$62,269	$71,164	$80,060	$88,956
15,000	9	$58,967	$67,391	$75,814	$84,238
25,000	14	$56,861	$64,984	$73,107	$81,230
Assumptions: 50% of eligible patients enroll in PCMH, Payer mix: 70% commercial; 15% Medicaid; 15% Medicare/Over 65					

Incentive Payments Derived from Shared Savings

Assumptions

- Medical homes will generate savings through better care management, coordination with other providers, and ongoing support from team members and fellow patients.
- Patients have fewer hospitalizations, reduced use of hospital emergency departments, more appropriate use of high cost tests, increased use of higher value drugs, and use of electronic consultations rather than office visits.
- Most of the savings will be through avoided hospitalizations and emergency department visits.

Shared savings method

The shared savings methodology is based on the average total cost for treating a patient.

1. Total commercial savings = (average for commercial patients(t+1) - (PPPM + adjusted average for commercial patients(t+0)))*attributed commercial patients* Practice share
2. Total Medicaid savings = (average for Medicaid patients(t+1) - (PPPM/MD + adjusted average for Medicaid patients(t+0))*attributed Medicaid patients* Practice Share
3. Total Medicare savings = (average for Medicare patients(t+1 - (PPPM/MC + adjusted average for Medicare patients(t+0))*attributed Medicare patients)*practice share
4. Total savings due to practice = (total commercial savings + total Medicaid savings + total Medicare savings)*PCMH practice size adjustment * NCQA PPC-PCMH recognition adjustment .

Measures for Inclusion in PCMH Pilot
Process Measures

Practices would collect data on these and would be required to report on specific measures that can be determined from a detailed NCQA recognition report on PPC-PCMH.

- Measures increase as practices move from NCQA Level 1+, Level 2+ and Level 3+. A fourth level is assumed to be Level 3+ with a 100% score on PPC-PCMH.

- Level 1+ includes the measures most closely associated with preventing avoidable costs, to the system and the patient, in the short term.

- Level 2+ includes measures showing that the practice is using more sophisticated electronic tools and has the capability for further transforming its work from just providing patient-initiated visits to actively working with patients.

- Level 3+ full transformation to a medical home; the added score should indicate reaching out to patients beyond those at highest acuity.

- Highest level—100% score on PPC-PCMH in addition to 3+ requirements—indicates well-rounded transformation to a medical home and effective use of care coordination personnel. See Hand-out

Quality Measures for Inclusion in PCMH Pilot

Phase 1	Targets: stretch goals for practices to work toward success.
Heart/Stroke	
Patient Count	TBD
Blood Pressure Management	≥ 75%
Complete lipid profile	> 80%
LDL Cholesterol Management	≥ 50%
Use of aspirin or another anti-thrombolytic	≥ 80%
Tobacco Use Assessment	≥ 80%
Tobacco Cessation Intervention	≥ 80%
Lipid lowering therapy	≥ 80%
Depression	
Patient count	TDB
Depression Screening	≥ 40%
Patient Experience	
Patient Experience	

Meeting Clinical Measure Thresholds is a hurdle to achieving shared savings.

Payers recommend linking quality benchmark to measures that plans use and understand , e.g., Quality Compass

Pediatric measures will require more thought.

Legal agreements with carriers and practices

Contracts will be executed between payers and providers using common contract elements:

- Requirements of the payer/practice;
- Reward structure;
- Enrollment of patients;
- Grievance process;
- Leaving the pilot.

Sure to provoke discussions:

- Provider/state contract overlay with provider payer contract;
- Practices must be in-Network to participate as PCMH practices.

Start of the Evaluation Effort

Law was prescriptive…

- improvements in health care delivery;
- increased patient satisfaction with care;
- increased clinician and staff work satisfaction;
- improved clinical care processes;
- lower total costs of care;
- increased access to care coordination;
- adequacy of enhanced payments to cover expanded services; and
- reductions in health disparities.

Maryland's evaluation approach will focus on a mix of methods…

- evaluation using claims, condition-specific quality measures, and a limited use of patient/provider satisfaction surveys;
- patient and practice surveys are being viewed cautiously due to limited options and possible expense;
- RFP will be released in August.

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In Summary:
Maryland Medical Home Pilot – Key elements

- ✓ Primary care practices – physician and nurse practitioner led pediatrics, family practice, internal medical, and geriatric practices.
- ✓ Fifty practices, 200 providers, and at least 200,000 patients will be enrolled in the pilot. Prime objective is 200,000 patients. May be subject to adjustment due to CMS pilot.
- ✓ Practices will participate in a practice transformation collaborative funded through *Community Health Resources Commission + other stakeholder funds.*
- ✓ Practices must apply for NCQA PPC-PCMH Level 1 recognition (plus) within 6 months of acceptance and Level II (plus) within 18 months.
- ✓ Patients will be assumed to participate, but may opt-out, except for the Medicaid population.
- ✓ Practices will receive ***Fixed Payment + Incentive Payment*** (must meet performance standards).
- ✓ Fixed payments will be adjusted by payer status, NCQA recognition, and practice size.
- ✓ Incentive payments based on savings from historical trend. Fixed payments will be net from savings before incentive payments applied.

Implementation

2010

- June – July — 6 PCMH Symposia for primary care providers
- August — CMS Grant Submission Due
- July-Sept — Technical Seminars: Is the Pilot right for your practice?
  Practices apply for program
- October — Selection committee identifies practices
  Carriers sign participation agreements
- November — Practices sign participation agreement
  Award of transformation contract

2011

- January — Launch of transformation and learning collaborative underway
  Award of Evaluation Contractor
  Practices start patient enrollment
  Application for NCQA PPC-PCMH recognition begins
- March — Applications due to NCQA by March 31, 2011
  Payers begin PPPM payments
- July — Participating provider practices begin operating as Medicaid PCMHs